DMAS REQUEST – EXTENSION OF PSYCHIATRIC TREATMENT

Recipient Name:_____ Age:____ Medicaid ID #:_____

Date of First Service:_____ Diagnosis: _____

Provider Name: _____ Provider ID #: _____

Specific Symptoms & Behaviors of Present Psychiatric Illness:

Plan of Treatment: ☐ Individual Psychotherapy _____Sessions per month

☐ Group Therapy _____Sessions per month

☐ Family Therapy _____Sessions per month

Participants: _____

☐ Medications (Include name of med, dose and frequency)

Goals of Treatment (Include separate goals for each therapy received)

Prognosis:

Previous Treatment Received:

Specific Progress Toward Treatments Goals:

Client Specific Reasons for Extension:

Signature: _____ Title: _____ Date: _____

For Fax Submissions to DMAS:
Local (804)225-2603
Toll-Free (866)248-8796